IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 4, 2008

Karlene Magee, Administrator
Cummunity Restorium
PO Box 419
Bonners Ferry, ID 83805

Dear Ms. Magee:

On January 10, 2008, a complaint investigation survey was conducted at Community Restorium. The survey was conducted by Maureen McCann, RN and Donna Henscheid, LSW. This report outlines the findings of our investigation.

Complaint # ID00003115

Allegation #1: A resident's right to refuse treatment was violated. An alarm bracelet was placed on the resident's ankle against the resident's wishes.

Findings #1: Based on observation, interview and record review it was determined the resident did have an ankle bracelet alarm in the past, but no longer wore one.

On January 10, 2008 at 1:45 PM a door buzzer was observed to be working, alerting staff whenever someone entered or exited the building.

On January 10, 2008 at 2:50 PM the resident was observed to not be wearing an ankle bracelet.

On January 10, 2008 at 2:50 PM the resident stated that she used to go to the family home down the road from the facility but that she no longer left the facility to "go down the hill (to the family home) because my kids don't want me to go alone." She further stated a family member worked locally and would come to the facility anytime she needed anything."

Review of the resident's NSA dated July 13, 2007 documented, "Resident becomes anxious over limitations that ankle bracelet have involved. Is aware that leaving the confined area of the facility will percipitate an alarm. Resident has voiced her frustration that she is limited to a designated area." Therefore, a new plan had been

initiated which documented if the resident leaves the facility to visit a family member, the family member will first be called on the phone to watch for the resident. Further, the family member will return the resident back to the facility once the visit is completed.

Conclusion #1: Substantiated. However, the facility was not cited as the alarm bracelet had been removed and a new plan initiated to assure the resident's safety.

Allegation #2: A housekeeper was verbally abusive to a resident.

Findings#2: Based on interview and record review it was determined a staff member had verbally abused a resident, however the staff member was no longer employed at the facility.

On January 10, 2008 the administrative assistant stated a staff member was reported to the administrator after being verbally abusive toward a resident. The incident was witnessed by two people. The administrative assistant stated a staff member had been terminated by the facility since the incident occurred.

On January 10, 2008 at 2:55 PM the resident stated, "the bad apple has left, she no longer works here...", referring to the staff member.

An incident report dated May 7, 2007 documented the staff member yelled at (the resident) "Don't you tell me" and shook her finger at the resident."

Conclusion #2: Substantiated. However, the facility was not cited as they acted appropriately by terminating the employee.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

MM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Maureen McCann, RN, Health Facility Surveyor

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Dear Ms. Magee:

On January 10, 2008, a complaint investigation survey was conducted at Community Restorium. The survey was conducted by Maureen McCann, RN and Donna Henscheid, LSW. This report outlines the findings of our investigation.

Complaint # ID00003396

Allegation #1: The facility was not following special diets: diabetic, no added salt and Coumadin.

Findings: Based on observation, interview and record review it could not be determined that the facility was not following special diets.

A list observed in the kitchen, dated December 20, 2007 contained all the residents' names, their diets, food allergies and special diet requests.

"Diet cards" were observed at each table in the dining room to assist new staff to remember what each resident ' s diet and food preferences (such as small portions, etc.) were.

On January 10, 2008 2:10 PM, a kitchen staff member stated there were residents in the facility that were on therapeutic diets. She further stated a list of all residents and their diets hung on the wall in the kitchen.

On January 10, 2008 at 2:40 PM a resident stated she was on a diabetic diet and "gets the right food" at meals.

On January 10, 2008 at 2:45 PM a resident stated she cannot eat spinach because she was taking Coumadin. Further, she stated, "I don't think they give me spinach because they know I'm on Coumadin."

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #2: Residents complained about the poor quality of food.

Findings: Based on interview it could not be determined that residents had complained about the poor quality of food.

On January 10, 2008, 9 of 9 residents interviewed about the quality and palatability of the food served by the facility denied any problems or concerns.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #3: Resident's were intimidated by "food service" staff after complaining about the poor quality of food.

Finding: Based on interview it could not be determined that residents were intimidated by "food service" staff after complaining about the poor quality of food.

On January 10, 2008, 9 of 9 residents interviewed about the quality and palatability of the food served by the facility denied any problems or concerns.

On January 10, 2008, 8 of 9 residents interviewed about how they had been treated by staff, denied having any problems. 1 of 9 residents stated the staff member that she "did not get along with", no longer worked at the facility and that staff member did not work in the kitchen.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #4: The facility administrator throws out Incident Reports completed by caregivers.

Findings: Based on record review it could not be determined that the facility administrator threw out incident reports that caregivers had completed.

Review of the facility's Incident Report log on January 10, 2008 revealed 3 incident reports completed during June, July and August of 2007. The reports were all completed by caregivers then reviewed and signed by the administrator.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #5: Residents are not assisted with ADL's resulting in poor hygiene.

Finding: Based on observation it could not be determined that residents were not assisted with ADLs.

On January 10, 2008 during the survey, residents were observed to be wearing clean clothing, free from body odors, urine odors, hair was brushed and/or styled as well as teeth and/or dentures were clean. For those residents wearing eyeglasses, their eyeglasses were clean.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #6: Caregivers were unable to reach the facility administrator over weekends.

Finding: Based on interviews it was determined that caregivers did have difficulty reaching the administrator present at the time when the complaint was made in July 1007.

On January 10, 2008 during an interview with both the current administrator as well as the current administrative assistant, both agreed that the prior administrator was difficult to reach on weekends. They explained that they both were employed at the facility during July 2007, however in different positions. They further stated that the prior administrator's last day at the facility was September 4, 2007.

Conclusion: Substantiated: However, the facility was not cited as the administrator is no longer employed with the facility.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

MAUREEN MCCANN, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

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